GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 17, 2019

Faith Giplaye
Acare Human Services, Inc.
3210 Eastern Ave. S.E.
Grand Rapids, MI 49508

RE: License #: AM410394626
Investigation #: 2020A0357004
Acare Home

Dear Mrs. Giplaye:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Arlene B. Smith

Arlene Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AM410394626
Investigation #:	2020A0357004
Complaint Receipt Date:	11/13/2019
Investigation Initiation Date:	11/13/2019
Report Due Date:	12/13/2019
Licensee Name:	Acare Human Services, Inc.
Licensee Address:	3210 Eastern Ave. S.E. Grand Rapids, MI 49508
Licensee Telephone #:	(616) 204-4651
Administrator:	Faith Giplaye
Licensee Designee:	Faith Giplaye
Name of Facility:	Acare Home
Facility Address:	2720 44th St. SE Kentwood, MI 49512
Facility Telephone #:	(616) 204-4651
Original Issuance Date:	07/11/2018
License Status:	REGULAR
Effective Date:	09/14/2019
Expiration Date:	09/13/2021
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED, ADED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Standing water was observed on the floor of the laundry room.	Yes
Light bulbs in the laundry area were not working.	No
There is one staff person on duty. One resident uses a walker and wheelchair and there are concerns that the staff person on duty would not be able to evacuate all of the residents in a safe and timely manner.	No
E-Scores have not been updated since Resident A returned from a Rehab facility.	Yes
E-scores have not been completed.	Yes
There were no Individual Plans of Service on file for residents receiving personal care/community living support services.	Yes
A fire evacuation chart was present but there were no specific instructions on how to evacuate the home.	Yes
The licensee is not conducting overnight fire drills.	Yes
Resident A requires the use of a wheelchair and the home does not have a ramp.	Yes
The licensee does not provide transportation for residents.	No
Additional Findings	Yes

III. METHODOLOGY

11/13/2019	Special Investigation Intake 2020A0357004
11/13/2019	Special Investigation Initiated - Telephone Telephoned Recipient Rights, network 180,
11/13/2019	Contact – Telephone called Tae Naumes of network 180.
11/19/2019	Contact - Telephone call made To Hans Giplaye the owner of the facility.
12/04/2019	Contact - Telephone call made To Hans Giplaye, the owner and to Laura Esese, the Administrator.
12/05/2019	Inspection Completed On-site Reviewed facility records.
12/05/2019	Contact - Face to Face

	Interview with Resident A, Laura Esese, the Administrator, Faith Giplaye, the Licensee Designee, and Direct Care Staff, Rhonda VanDyke.
12/05/2019	Exit Conference with the Licensee Designee, Faith Giplaye face-to face while I was doing the investigation.
12/10/2019	Contact – Telephone call made To Hans Giplaye
12/11/2019	Contact – Telephone call received From Laura Esese
12/12/2019	Contact – Telephone Call To Hans Giplaye.
12/17/2019	Exit conference conducted by telephone with Licensee Designee, Faith Giplaye.

On 11/13/2019, I received a complaint from LARA/BCH-Child & Adult Licensing, Complaint Intakes dated 11/12/2019. This complaint was a result of a recent inspection of the home and included the following potential Licensing rule violations:

- Standing water was observed on the floor of the laundry room.
- Light bulbs in the laundry area were not working.
- Inadequate staffing.
- E-scores not updated when a resident returned from Rehab.
- E-scores not completed as required.
- There were no Individual Plans of Service.
- There were no specific instructions for evacuating during a fire.
- The Licensee is not conducting overnight fire drills.
- Resident A requires the use of a wheelchair and the home has no ramps.
- The licensee does not provide transportations for the Residents.

An additional allegation was made that the home did not have an emergency plan in place as to where the residents would go if they had to leave for a few hours or overnight. This allegation was not investigated as the administrative rules do not require the licensee to provide an alternative living arrangement.

ALLEGATION: Standing water was observed on the floor of the laundry room.

INVESTIGATION: On 09/12/2019, I was in the home and in the laundry room and I did not observe any standing water on the floor of the laundry room. On 11/19/2019, I spoke by telephone with Hans Giplaye, the owner of the AFC home. Mr. Giplaye confirmed that there has been a problem with water leaking from the washing

machine the laundry room and stated he has contacted the landlord Liem Hoang, who they lease the home from and asked him to repair the water in the laundry room. Mr. Giplaye stated that Mr. Hoang had been to the facility and was working on the water leak issue. He referred me to the Administrator, Laura Esese for the other issues.

On 12/05/2019, Ms. Giplaye, Ms. Esese and I inspected the laundry room on the lower level of the home. I observed water pooling around the washing machine and to the side of the washing machine. They both explained that Mr. Hoang had hired someone to fix the water problem and he was expected to do the work at the facility on December 6 or 7 2019. Ms. Giplaye stated that it was the landlord's responsibility to repair the water issue and they had contacted him before. She reported that they have asked him to do the proper repairs, quickly. This original complaint was received on 11/12/2019 and the repair for the water has not been completed as of the date of the inspection 12/05/2019.

On 12/05/2019, I conducted a face-to-face exit conference with Ms. Giplaye and she agreed with my findings. She did not know when the repairs would be completed.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises**
	(6) All plumbing fixtures and water and waste pipes shall be properly installed and maintained in good working condition. Each water heater shall be equipped with a thermostatic temperature control and a pressure relief value, both of which shall be in good working condition.
ANALYSIS:	It was reported that there was standing water pooled in front of the washer and dryer in the laundry room. On 12/05/2019, I observed standing water in front of the washing machine and to the side of the washer. The pooling water had not been repaired by this date. Ms. Giplaye stated that the water problem was for the landlord, Mr. Liem Hoang, to repair and they had contacted him. She understood that someone was coming to evaluate and address the water problem on 12/6-7/2019.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: **Light bulbs in the laundry area were not working.**

INVESTIGATION: On 12/05/2019, Ms. Giplaye, Ms. Esese and I inspected the laundry room on the lower level of the home. I observed all the lights were working.

Ms. Esese stated that the Direct Care Staff did not know where the light bulbs were located. She said the light bulbs were replaced and now they are all working.

On 12/05/2019, I conducted a face-to-face exit conference with Ms. Giplaye and she agreed with my findings.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	It was reported that there were light bulbs tin the laundry room were not working. On 12/05/2019, I inspected the laundry room and the lights were all working. Ms. Esese stated that the staff on duty did not know where the supply of light bulbs were located. She confirmed that the light bulbs had been replaced and they all are working correctly.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: There is one staff person on duty. One resident uses a walker and wheelchair and there are concerns that the staff person on duty would not be able to evacuate all of the residents in a safe and timely manner.

INVESTIGATION: On 12/05/2019, I was in the AFC home and was able to observe six residents and some I have known for several years. They were dressed appropriately. They came and left the living room as they pleased. I have known them to be able to do all of their own personal care.

On 12/05/2019, I conducted an interview with the Direct Care Staff, Rhonda VanDyke. She stated that she has worked in and out of this home for the last 18 years. She stated that all the residents who reside in the home are very independent and they do not require personal care. She said that some of them require occasional prompts or reminders. She also stated that the two residents that did live in the home and required more personal care had left the facility and had gone to a nursing home. She reported that they currently only have 10 residents and only Resident A requires the use of a wheelchair. She stated that she is able to take Resident A out of the home with her wheelchair and she had no problem. She reported that the minute the alarm goes off everyone moves very fast. I asked about Resident A and she reported that she can do her own personal care, go to the restroom on her own, dress herself, but she helps her in and out of the bathtub. I

asked Ms. VanDyke about Resident A's use of her walker or her wheelchair. She reported that Resident A likes to use the wheelchair and during a fire drill she takes Resident A out the front door and she lifts Resident A's wheelchair down the first step and the second step, and she reported that she has no difficulty. Ms. VanDyke stated that Resident H has dementia and she helps her with a shower and reminds her to clean herself after elimination. She said if she does not clean herself completely, she cleans her. She also stated that Resident D needs help with her shower and help with keeping her bedroom clean.

On 12/05/2019, Ms. Esese stated that she knew every resident well and she reported that they all can meet their own personal care needs. She said occasionally they may need some reminders, but they function very well. She acknowledged that the two residents that had moved out did require a higher level of care, but they are no longer in the facility. She also reported that Resident A's, Case Manager has determined that she needs to move into a nursing home, and they are currently searching for one. She stated that the staff do provide personal care for Resident H and Resident D. Ms. Esese stated she has watched Ms. VanDyke do the fire drills before and she gets everyone out. She said Ms. VanDyke recently did a fire drill at nighttime and she got everyone out in 2 minutes. Ms. Eesese stated that Resident K no longer lives in the AFC home and the case manage is seeking another placement for Resident A.

On 12/05/2019, Ms. Giplaye informed me that she had completed each resident's assessment plan and she provided verbal reassurance that all the residents were able to meet all of their own personal care needs. Occasionally some may need a verbal reminder, but they can do all of their own personal care. She reported that the staff have been able to evacuate all of the residents with no problems.

On 12/05/2019, I reviewed Resident A's assessment plan signed on 07/25/2018, by her guardian. This plan indicated that she does not move independently in the community due to a fall risk and she has significant vision loss. Under the section of Self Care Skill Assessment, bathing was checked with a "yes" that she does need help and the plan was that she will need assistance with bathing in and out of the tub and staff will assist her. Under Walking/Mobility, "yes" was checked that she needed help and the plan stated "Resident uses a walker for the most part. May need assistance as needed. Staff will assist if needed."

On 12/05/2019, I reviewed Resident A's Health Care Appraisal, signed by Jennifer White Home MP, NP-C. Her diagnoses included "Osteoporosis, Lumbar Stenosis, High Blood Pressure, COPD, Glaucoma, Breast Cancer and Legally Blind." Her Mental / Physical Status and Limitations, it read: "Depression/Anxiety, and unsteady gait." She also has Schizophrenia. Under the section of "Explanation of Abnormalities/Treatment Ordered:" "Restriction with ROM (Range of Motions) cervical spine. Kypnosis, reflexes (plus) 1 LE. Decreased ROM RLE LLE." (Right lower extremities and left lower extremities) This report stated that she was 62 inches tall, and her weight was 113.6 and she is 72 years of age.

On 12/05/2019, I observed Resident A sitting on at the dining room table eating her lunch and her walker was next to the table. I later went to see her, and she was in the restroom and she had her walker with her. Later on, I conducted an interview with Resident A in her bedroom. She was lying on her bed. She stated that she has a great deal of pain and it is easier for her to use the wheelchair. She said that the staff help her out of the home in her wheelchair during a fire drill.

On 12/05/2019, I reviewed the Licensee's proposed staffing pattern when the facility was opened. Their written plan was to have, "Minimum of one direct care staff person per 12 Residents (16 hours/day) in the facility during peak hours of 7:00 a.m. – 11:00 p.m. Minimum of one awake staff during sleep time with a plan stating how situations requiring more than one staff will be addressed. Consultant/Staff Hours: Both direct staff hours and behavior management consultant hours should exceed requirements set forth by the Behavioral Health and Development Disabilities Administration." I also reviewed the Original Licensing Study Report dated 07/11/2018 that I had completed, and Mr. Giplaye had acknowledged that the staff would be awake during the sleeping hours.

On 12/05/2019, I reviewed the fire drill records. Starting with 08/06/2018, through 05/07/2019 the times on the drills were 1:40 or below. On 06/01/2019 the time was 2 minutes with three residents were absent. On 07/02/2019 the times was recorded as 3 minutes and 5 seconds. On 08/01/2019 the time was 3 minutes with two residents were not present. On 09/11/2019 the time was 3 minutes with two residents missing for the drill. On 10/05/2019 the drill was conducted at 6:00 AM and the drill took 4 minutes and 2 seconds with one resident who was not present for the drill. The fire drill dated 11/06/2019 at 8:47 AM was recorded as 3 minutes with three residents were not present for the drill. These drills were found to be acceptable.

On 12/17/2019, I conducted a telephone exit conference with the Licensee Designee, Ms. Giplaye and she agreed with my findings.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	With one staff person on duty and one uses a walker, and another uses a wheelchair there are concerns that the staff person on duty would not be able to evacuate all of the residents in a safe and timely manner.

	The fire drills were reviewed, and the times were found to be acceptable. Ms. VanDyke, Direct Care Staff, Ms. Giplaye and Ms. Esese all confirmed that the staff have been able to evacuate all the residents, safety and with a timely procedure. Ms. Giplaye, Ms. Esese and Ms. VanDyke, all stated that the other current residents are able to do all of their personal care. They acknowledged the help to the residents acknowledged by Direct Care Staff. Ms. VanDyke. The licensee has met the required ratio of one direct care staff to 12 residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: E-scores have not been updated since Resident A returned home from a Rehab Facility.

INVESTIGATION: On 12/05/2019, I was in the facility. I requested to inspect the Resident's Evacuation Assessments on Resident A and the other residents. Ms. Esese explained that she was new to her position and was not aware that they were required to conduct the evacuation assessments within 30 days after the admission of each resident and at least annually thereafter. She stated they had completed fire drills on a monthly basis, but they did not complete the capability for Resident A or of each resident to evacuate their facility. I reminded Ms. Esese and Ms. Giplaye that when I was in the facility the last time, 09/12/2019, I had provided them with a copy of the information on Special Certification. Contained in that packet was all the required forms related to the appendix f of the 1985 life safety code. Ms. Esese stated that the former licensee had not taught them what was required to be completed for Special Certification. Therefore, she was not aware of the requirements and she acknowledged that they had not completed the capacity of each resident in evacuating the facility in the event of a fire, after a new resident was admitted, or after Resident A came back into the facility after being in Rehab.

On 12/05/2019, I conducted a face-to-face exit conference with the Licensee Designee, Faith, Giplaye and she agreed with my findings.

APPLICABLE RULE	
R 330.1803	**Facility environment; fire safety.**
	(5) The capability of the clients to evacuate a facility in the event of a fire shall be assessed using methods described in appendix f of the 1985 life safety code of the national fire protection association. Appendix f of the 1985 life safety code of the national fire protection association is adopted

	by reference as part of these rules. A copy of the adopted appendix f is available from the Department of Mental Health, Lewis Cass Building, Lansing, MI 48913, at cost. A copy of appendix f may also be obtained from the National Fire Protection Association Library, Battermarch Park, P.O. Box 9101, Quincy, Massachusetts 02269-9101, 1-800-344-3555. A prepaid fee may be required by the national fire protection association for a copy of appendix f. A price quote for copying of these pages may be obtained from the national fire protection association.
ANALYSIS:	E-scores have not been updated since Resident A returned to the home. Ms. Esese acknowledged that they had not completed the required forms on Resident A or on each resident to assess their capacity to evacuate the facility in the event of a fire after their admissions. There a preponderance of evidence that the Licensee did not completed the required resident evacuation score or the level of evacuation capability for this facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: E-scores have not been completed.

INVESTIGATION: On 12/05/2019, I requested to inspect the E-scores. Ms. Gilpaye and Ms. Esese provided a sheet entitled 2012 Life Safety Code, Worksheets 6.8.9.-Rating the Facility. This was completed by the former licensee and it was dated 07/02/2018 and documented as “Prompt.” They acknowledged that they have not completed the individual Resident Evacuation Assistance Score, nor have they completed the Level of Evacuation Capability for this facility. They have had new admissions of residents and failed to complete the required scores of each resident at admission and failed to complete required yearly report.

On 09/12/2019, I met Ms. Esese and she had just started her new position. I provided a packet of all of the information I had related to Special Certification which included how often fire drills are required and how to calculate the scores for each resident as well as the Level of Evacuation Capability Score. I gave this to Ms. Gilpaye and Ms. Esese. Neither of them seemed to have the knowledge of what is required for their Special Certification related to evacuation assessments.

On 12/05/2019, I conducted an exit conference face-to-face with the Licensee Designee, Faith Giplaye and she agreed with my findings.

APPLICABLE RULE	
R 330.1803	**Facility environment; fire safety.**
	(6) Evacuation assessments shall be conducted within 30 days after the admission of each new client and at least annually thereafter. The specialized program shall forward a copy of each completed assessment to the responsible agency and retain a copy in the home for inspection. A home that is assessed as having an evacuation difficulty index of "impractical" using appendix f of the life safety code of the national fire protection association shall have a period of 6 month from the date of the finding to either of the following: **(a) Improve the score to at least the "slow" category.** **(b) Bring the home into compliance with the physical plant standards for "Impractical" homes contained in chapter 21 of the 1985 life safety code of the national fire protection association, which are adopted by reference in these rules and which may be obtained from the Department of Mental Health, Lewis Cass Building, Lansing, MI 48913, at cost, or from the National Fire Protection Association Library, Battermarch Park, P.O. Box 9101, Quincy, Massachusetts 02269-9101, 1-800-344-3555. A prepaid fee may be required by the national fire protection association for a copy of the chapter 21 standards. A price quote for copying of these pages may be obtained from the national fire protection association.**
ANALYSIS:	On 12/05/2019, Ms. Gilpaye and Ms. Esese both acknowledged that they had not completed each resident's evacuation score, nor had they completed the level of evacuation capability for the facility. There a preponderance of evidence that the Licensee did not completed the required resident evacuation score or the level of evacuation capability for this facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: There were no Individual Plans of Service on file for residents receiving personal care/community living support services.

INVESTIGATION: On 11/13/2019 I spoke by telephone with Tae Naumes, Contract Manager, from network 180. She stated she was aware of the issues at Acare home.

She stated that network 180 has recently taken over the case management of residents and she explained that the new case managers needed more trainings. She reported that she would check with the supervisors and with other agencies on the importance of having the Person-Centered Plans completed on a timely basis and that they should be on the premises of the AFC home for the residents who are receiving Special Certification support.

On 12/05/2019, I met with Ms. Giplaye and Ms. Esese. They were able to provide one resident's Individual Plan of Service for Resident A. They identified that they had seven residents who were receiving Community Living Supports/Special Certifications. The seven residents are Resident A, Resident B, Resident C, Resident D, Resident E, Resident F and Resident G. Ms. Esese reported that they only had one Person Centered Plan, which is for Resident A. She also stated that she had contacted the case managers of each resident numerous times and requested the other residents' Individual Plan of Service, but as of this date she has not yet received the Individual Plans of Service for the other six residents.

On 12/05/2019 I conducted a face-to-face exit conference with the Licensee Designee, Faith Giplaye and she agreed with my findings.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.
ANALYSIS:	There were no Individual Plans of Service on file for residents receiving personal care/community living support services. Ms. Gilpaye and Ms. Esese both acknowledged they had only one Individual Plan of Service, which was for Resident A, but they did not have the other six residents' Individual Plans of Service.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: A fire evacuation chart was present, but there are no specific instructions on how to evacuate the home.

INVESTIGATION: On 12/05/2019, I observed the prominently posted drawing of each floor with red arrows showing the evacuation route to take out of the facility. There were no specific residents identified who require special assistance.

On 12/05/2019, I reviewed Resident A's file, including her assessment plan and her Health Care Appraisal. She was identified in these documents as a fall risk, has an

unsteady gait and is legally blind. She also chooses to use her wheelchair instead of her walker. These identified needs would have required the licensee to have a written plan for special assistance when Resident A is exiting the facility, especially during fire drills, medical and severe weather emergencies.

On 12/05/2019, Ms. Giplaye, Ms. Esese and Ms. VanDyke all identified that Resident A choses to use her wheelchair for evacuation during a fire drill. There were no written plans or instructions that Resident A requires special assistance.

On 12/05/2019, I observed the fire evacuation floorplan on both floors of the home. The evacuation route is identified by red arrows to the doors that exit to the outside.

On 12/11/2019 I spoke by telephone with Ms. Esese and she explained that she will be training the staff on 12/13/2019 on the procedures if there is a fire and she has developed a sheet to sign that they have been trained.

On 12/15/2019 Ms. Esese faxed me their plan for plan, “Fire In the Building.” This plan included the procedures they are to follow, which included the acronym of R-A-C-E. R- Rescue/Evacuate, A- Alert, C- Contain and E- Extinguish. This plan did not indicate to call 911. The plan she faxed to me had the following: “6.12 Fire Safety / Emergency Power System/ Fire In the Building. At the top of the page it read: “Gentiva Hospice.” It also had the following: “Emergency Preparedness Disaster Plan copyright 2016@ 2016 21st Century HCC.” This plan stated: “Fire drills are conducted quarterly. The Agency evaluates their response to the fire drill and communicates these results to personnel.” This is not the correct fire plan for the AFC home.

On 12/12/2019, I spoke to Hans Giplye, the owner of the facility and explained that their emergency procedure needs to be written out and they are to immediately evacuate all of the residents to an identified specific place and to account for each resident. If only one staff is on duty, they will call 911 after they have the residents evacuated and to not let anyone back into the home until the fire department has declared an all clear. I also explained that fire drills are to be conducted every month, not quarterly. He said he would work on the fire plan.

On 12/17/2019 I conducted a telephone exit conference with the Licensee Designee, Faith Giplaye and she agreed with my findings. She explained that Ms. Esese had the emergency written procedures completed including any residents that need special assistance.

APPLICABLE RULE	
R 400.14318	**Emergency preparedness; evacuation plan; emergency transportation.**
	(1) A licensee shall have a written emergency procedure and evacuation plan to be followed in case of fire, medical,

	or severe weather emergencies. The evacuation plan shall be prominently posted in the home. Residents who require special assistance shall be identified in the written procedure.
ANALYSIS:	A fire evacuation chart was present, but there are no specific instructions on how to evacuate residents from the home. The written fire plan did not include the meeting places for the residents to go to meet at and the plan did not include to call 911 and the plan was for another agency and not for this AFC home. Ms. Giplaye, Ms. Esese and Ms. VamDyke all identified Resident A has special needs. I reviewed Resident A's file and found she is a fall risk with an unsteady gait, is legally blind and choses to use her wheelchair during the evacuation for a fire drill. Resident A does require special assistance to evacuate the facility. She was not identified as requiring special assistance. There is preponderance of evidence that the Licensee did not have written procedures for a fire emergency and the resident who required special assistance did not have a written procedure.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The licensee is not conducting overnight fire drills.

INVESTIGATION: The licensee Acare Human Services, Inc. was received an original license on 07/11/2018.

On 12/05/2019, Ms. Giplaye provided me with the fire drill records which I reviewed.

- 08/06/2018, 5PM, second shift.
- 09/10/2018, 11AM, second shift.
- 10/10/2018, 6AM 3rd. shift.
- 11/12/2018, 2PM, second shift.
- 12/03/2018 1PM, first shift.
- 01/06/2019, 3PM second shift.
- 02/07/2019, 5PM, second shift.
- 03/11/2019 3:30PM, second shift.
- 04/16/2019, 12:20 (noon), first shift.
- 05/09/2019, 3PM second shift.

- 06/01/2019, 1PM second shift.
- 07/02/2019, 1:30PM, second shift.
- 08/01/2019, 3:30 PM, second shift.
- 09/11/2019, 3PM, second shift.
- 10/05/2019, 6AM, 3rd. shift.
- 11/06/2019, 8:44AM. first shift.

A review of the fire drills indicates there were only two fire drills conducted on the 3rd shift, both at 6AM, from 08/06/2018 through 11/06/2019.

Ms. Giplaye was unable to explain why they did not complete the fire drills on 3rd shift, (sleeping time) only two times in 16 months.

On 12/17/2019 I conducted an exit conference by telephone with the Licensee Designee, Faith Giplaye and she agreed with my findings.

APPLICABLE RULE	
R 400.14318	**Emergency preparedness; evacuation plan; emergency transportation.**
	(5) A licensee shall practice emergency and evacuation procedures during daytime, evening, and sleeping hours at least once per quarter. A record of the practices shall be maintained and be available for department review.
ANALYSIS:	I reviewed the fire drills from 08/16/2018 through 11/06/2019 and there were only two sleeping hours fire drills conducted during this period. Ms. Giplaye was not able to provide an explanation as to why the fire drills were not completed during sleeping hours at least once per quarter. There is a preponderance of evidence that the recorded fire drills were not completed during sleeping hours once per quarter.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A requires the use of a wheelchair and the home does not have a ramp.

INVESTIGATION: On 12/05/2019, I was at the AFC home. Ms. Esese reported that Resident A does choose to use her wheelchair over her walker. Ms. Giplaye and Ms. Esese both acknowledged that they do not have any ramps from the main floor. They reported that they have spoken to Resident A's Supports

Coordinator/Case Manager and explained that Resident A is using the wheelchair and they do not have ramps. They reported that the Case Manager is working to have Resident A moved to a nursing home, but it takes time. Resident A has been in the home since 2012.

On 12/05/2019, I conducted a face-to-face interview with Resident A and she acknowledged that she does choose to use her wheelchair rather than her walker because the use of the walker causes her extreme pain. She reported that during the fire drills the staff take her out of the facility in her wheelchair and lift her down the first step and then they put her on the front porch.

On 12/05/2019 I conducted a face-to-face exit conference with the licensee Designee, Ms. Giplaye and she agreed with my findings.

APPLICABLE RULE	
R 400.14509	**Means of egress; wheelchairs.**
	(1) Small group homes that accommodate residents who regularly require wheelchairs shall be equipped with ramps that are located at 2 approved means of egress from the first floor.
ANALYSIS:	Ms. Gilpaye and Ms. Esese both acknowledged that Resident A uses a wheelchair. Resident A also acknowledged that she uses a wheelchair because the use of the walker causes her great pain. There is evidence that Resident A uses a wheelchair most of the time and the home is not equipped with any wheelchair ramps.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: **The licensee does not provide transportation for residents.**

INVESTIGATION: On 12/05/2019, I was in the facility and I met with Ms. Esese and she explained that the residents are very independent, and they secure their own transportation including public transportation of the city buses. They call 911 in a medical emergency situation. In addition, family members, and/or friends provide transportation as needed.

On 12/12/2019, I spoke to Hans Giplaye and he stated that they have provided transportation when a resident requires a blood draw, in the past. He stated that the residents are independent, and they can use public transportation because they know how to use it.

On 1217/2019, I conducted a telephone exit conference with the Licensee Designee, Faith Giplaye and she agreed with my findings.

APPLICABLE RULE	
R 400.14318	**Emergency preparedness; evacuation plan; emergency transportation.**
	(6) A licensee shall assure emergency transportation through the use of recognized available community service or vehicle that is owned by the licensee, administrator, or direct care staff on duty.
ANALYSIS:	The Provider does not provide transportation for residents as they use public transportation. Ms. Esese stated that in a medical emergency they call 911. The residents can make their own arrangements for their transportation. There is no evidence found during this investigation for a rule violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: On 12/05/2019, while in the home I reviewed Resident A's file. The AFC – Resident Care Agreement (RCA) was signed on 07/25/2018 and had not been updated since that date.

On 12/17/2019 I conducted a telephone exit conference with the Licensee Designee, Faith Giplaye and she agreed with my findings.

APPLICABLE RULE

R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.
ANALYSIS:	Resident A's Resident Care Agreement was not completed on an annual basis.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 12/05/2019, while in the home I reviewed Resident A's file. The assessment plan was completed but not signed by the licensee.

On 12/05/2019, I reviewed Resident I's assessment plan. The assessment plan was not signed by Resident I's Legal Guardian and therefore was not complete. The section V. Medications taken at time of assessment with the name of the medication, Who Prescribed, and the Dosage. The section was not completed.

On 12/17/2019 I conducted a telephone exit conference with the Licensee Designee, Faith Giplaye and she agreed with my findings.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable and the licensee. A Licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A's assessment plan was not signed by the licensee and Resident I's assessment plan was not signed by Resident I's guardian. The resident's medications and who had prescribed the medication and the dosage were not completed.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 12/05/2019, while in the home I reviewed Resident A's file. Resident Funds Part I was signed by the Resident A's guardian and not signed by

the Licensee Designee. Ms. Giplaye acknowledged that she did not have an understanding of the need for her to sign Resident Funds Part I, declaring that she did not have ownership of the resident monies. I also reviewed Resident A's Resident Funds Part II. This form requires the licensee to record Resident Funds of payment to the licensee. I observed that the form to have been completed by the former licensee. The last entry was dated 07/11/2018. Ms. Giplaye acknowledged that she was not aware that the payment was to be entered each month. I asked her if she had completed any of the Resident Funds Part II Forms for the other residents. She acknowledged that she was not aware of the requirement to enter the Resident Funds payment on a monthly basis, so she had not completed them.

On 12/05/2019 I completed a face-to-face exit conference with the Licensee Designee, Faith Giplaye and she agreed with my findings.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Resident A's Resident Funds Part 1 was signed by the guardian and not by the Licensee Designee. Resident A's Resident Funds Part II was not completed by the licensee. The former licensee's last entry was made on 07/11/2018. The Licensee Designee, Faith Giplaye, acknowledged that she had not completed the Resident Forms Part II for Resident A or for any of the current Residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 12/05/2019, I reviewed the book on all of the residents' Funds Form Part II. All of the Funds Part II forms were completed by the former licensee and they all ended on 07/11/2018. The Licensee, Acare Human Services, Inc. had not made any entries on the Funds Part II Form. Ms. Giplaye stated that she was not aware that the Funds Part II Form had to be completed and therefore she did not provide, a complete account on the required basis or at the discharge of a resident.

On 12/17/2019 I completed a telephone exit conference with Ms. Giplaye and she agreed with my findings.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(13) A licensee shall provide a complete accounting, on annual basis and upon request, of all resident funds and valuables which are held in trust and in bank accounts or which are paid, to the home, to the resident, or to his or her designated representative. The accounting of a resident's funds and valuables which are held in trust or which are paid to the home shall also be provided, upon the resident's or designated e\representative's request, not more than 5 banking days after the request and at the time of the resident's discharge from the home.
ANALYSIS:	All of the resident's Funds Part II Form were not competed and therefore they were not sent to the resident or to the designated representative, on the required annual basis or at the time of a resident's discharge.
CONCLUSION:	**VIOLATATION ESTABLISHED**

INVESTIGATION: On 12/05/2019, I was in the home for a complaint inspection. I conducted a face-to-face interview with the Direct Care Staff, Rhonda VanDyke. She explained that there is only one other staff that works in the home. She explained that she works every other weekend and her schedule is three or four days in a row and the other staff does the same. I asked her where she sleeps when she works three to four 24-hour days. She pointed to the couch in the living room and said I sleep on the couch and so does the other staff. She stated that she wants to be there for the residents if they have needs during the night. She explained that Ms. Esese is fixing up a staff bedroom in the lower level of the home for the staff to sleep in.

On 12/05/2019, I explained to Ms. Esese and Ms. Giplaye that staff cannot sleep in the living room because it is a room not ordinarily used for sleeping and there is a primary means of egress, the front door.

On 12/17/2019 I completed a telephone exit conference with the Licensee Designee, Faith Giplaye and she agreed with my findings.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally**
	(2) A living room, dining room, hallway, or other room that is not ordinarily used for sleeping or a room that contains a required means of egress shall not be used for sleeping purposes by anyone.
ANALYSIS:	Direct Care Staff, Rhonda VanDyke, acknowledged that she works several days in a row and she sleeps on the couch in the living room. She acknowledged that the other direct care staff also sleeps on the couch. The living room contains one of the required means of egress. There is a preponderance of evidence for a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend issuance of a provisional license.

On 12/17/2019, I conducted a telephone exit conference with Faith Giplaye, and she verbally agreed to accept a provisional license. She also agreed to put her written statement of acceptance of the provisional license in her plan of correction which she will sign.

Arlene B. Smith 12/17/2019

Arlene B. Smith MSW Date
Licensing Consultant

Approved By:

12/17/2019

Jerry Hendrick
Area Manager

Date